SERVICE DELIVERY SYSTEM IN INDUCED ABORTION

A REPORT

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Parivar Seva Sanstha, established in 1978
and affiliated to Marie Stopes International, U.K.
is a pioneering social service initiative in the
sphere of reproductive health and family welfare.
Through its network of Marie Stopes Clinics and
extension projects, the Sanstha has been
providing quality services.

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WORKSHOP ON SERVICE DELIVERY SYSTEM IN INDUCED ABORTION

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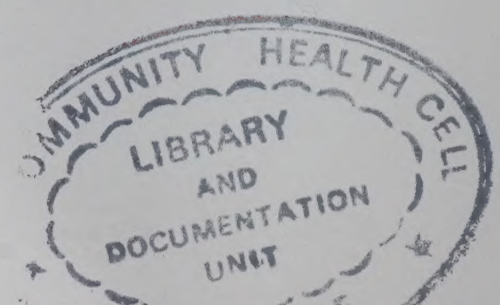

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Executive Summary

A workshop on 'Service Delivery System in Induced Abortion' was organised in February 1994 by Parivar Seva Sanstha, a non-governmental organisation that has been a pioneer in India in the field of reproductive health, with support from the Ford Foundation.

The workshop was motivated by the high levels of abortion related mortality and morbidity that exists in the country, despite the liberalization of abortion through the Medical Termination of Pregnancy (MTP) Act, as early as in 1971. According to current estimates, illegal, backstreet abortions continue to outnumber legal ones, with as many as ten illegal abortions for every legal abortion [1].

The workshop discussed factors contributing to this situation, and proposed a set of recommendations which, if implemented in earnest, could make a significant difference in terms of reducing preventable mortality and morbidity in women who are in the prime years of their lives.

ISSUES ADDRESSED

Some of the major issues highlighted by the workshop are:

- The MTP legislation has many loopholes which lead to faulty implementation, and to the persistence of illegal abortions.
- There is a lack of adequate infrastructural support for the provision of MTP services, in terms of approved MTP centres, equipment and trained personnel. The limited facilities available are inequitably distributed across the states and between the rural and urban areas.
- Training facilities for MTP are grossly inadequate. There are several constraints in adherence to the current training curriculum, and in particular, to the requirements for practical training. Consequently, even trained personnel are not adequately equipped to carry out MTPs independently in a Primary Health Centre/Community Health Centre setting.
- The quality of services in public sector MTP centres leaves much to be desired. Improvement in service quality alone could dissuade many women from using unlicensed facilities and untrained service providers, at high costs to their health. The linking of MTP with compulsory adoption of contraception represents another deterring factor in the use of public sector services.
- Inadequate attention is being given to the proper construction and dissemination of publicity and educational material on MTP and related issues. Consequently, a majority of the women do not know that abortion services are legal and are supposed to be available free of cost in government facilities.
- A severe lack of funding affects the maintenance and expansion of MTP centres, conducting training programmes and the provision of equipment to the centres.
- Research on abortion which examines the current situation and can aid policy making is virtually non-existent.

RECOMMENDATIONS

The principal recommendation of the workshop is related to the **formation of a committee** to work out the details and logistics of implementing the recommendations, covering a wide range of issues, which are summarised below:

(i) Improving **access to safe and legal abortions** by strengthening the public health infrastructure, rationalising the provisions of the MTP Act of 1971, encouraging the role of NGOs, and investigating new service delivery approaches.

(ii) Prioritization of **training** medical and non medical personnel in counselling and MTP procedures; increasing the number of training centres including authorisation of non-governmental organizations for this purpose; making the training curriculum more effective and providing refresher courses.

(iii) **Public education and communication** to enhance awareness of MTP legislation, types and location of services offered and to stress the need for information to encourage responsible parenthood at school and college level.

(iv) Situational analysis **research** on abortion services, the needs and motives of women seeking abortion and alternative service delivery approaches.

(v) Identification of sources of **funding** for the MTP programme.

Introduction

Abortion is a reproductive health measure that enables women to opt out of an unintended or unwanted pregnancy without endangering her life and well-being. It is both a proxy indicator of unmet need for family planning, and a sensitive indicator of gender inequality. Ensuring women's access to safe abortion services may therefore, be seen as an essential component of ensuring women's right to safeguard their health.

In 1971, India became one of the first countries in the world to pass legislation granting liberal social and socio-medical grounds for the termination of unwanted pregnancies. This legislation, known as the Medical Termination of Pregnancy Act of 1971, was the government's response to the high incidence of illegal abortions taking place in India in the 1960s and 1970s, with grave consequences to maternal health and well-being.

Paradoxically, in the 1990s, almost twenty five years after the liberalisation of abortion, and forty years of existence of a state-sponsored family planning programme, many more abortions may be taking place than at the time of legalization. Most of these are to terminate unplanned, unwanted pregnancies. Even more distressing is the indication that illegal and backstreet abortions today outnumber the legal procedures by a ratio of as much as 11 to 1 [1].

Further, India's incidence of medically hazardous, second trimester abortions is noted to be one of the highest amongst countries without legal restrictions on abortions [2]. Two major reasons for this are :

a) the high incidence of sex-selective abortions of female foetuses, since sex determination tests can be done only after twelve weeks.

b) women sometimes do not recognise their pregnancy till after the first trimester, possibly because of their often irregular menstrual cycles owing to poor health; or their reluctance to reveal their pregnancy as it is sometimes considered 'inauspicious'.

The resulting scenario is one of high abortion mortality — 11 to12% of maternal deaths in rural India is due to septic abortions [3] and morbidity ranging from chronic ill-health to infertility.

In recognition of the importance of unsafe abortions as a cause of reproductive ill-health in India, and its relative neglect at the policy level, Parivar Seva Sanstha organised a workshop on 22-23 February 1994 in Agra, entitled 'Service Delivery System in Induced Abortion', with support from the Ford Foundation.

Participants included not only gynaecologists and obstetricians but also representatives from women's organizations, government officials, non-governmental organizations and the research community.

The **objectives** of the workshop were to:

- ☆ Review the current situation after studying available data, including the MTP Act of 1971.
- ☆ Devise means of improving access to safe and legal abortions.
- ☆ Evolve strategies of securing better quality of care.

- ☆ Seek to improve the efficacy of Information, Education and Communication strategies.
- ☆ Work towards securing the enhancement of training facilities.
- ☆ Identify possible sources of funding for the MTP programme.

The two day workshop began with a session in which papers were presented which gave an overview of the status of abortion in India and highlighted some of the major problems which need to be addressed. Findings from situational analysis from states helped place these issues in context. Participants then broke up into six groups each addressing a specific area of concern, and deliberated on the recommendations for future action. The subjects addressed by the six **working groups** were:

1. Policy issues, Resource allocation and Legal aspects in abortion.
2. Improving quality of abortion services: Medical aspects.
3. Improving quality of abortion services: Non-medical aspects.
4. Training and Licensing issues.
5. Technology and New approaches.
6. Research needs in abortion.

In the following pages, the issues raised under the various areas of concern, and the recommendations made therein are summarised.

SEX SELECTIVE ABORTIONS

The deep-rooted desire for a male child in the Indian society, fuelled by a variety of social, religious and economic reasons, has resulted in large scale second trimester abortions following sex-determination tests. Selective abortion of the female foetus is happening in urban and rural areas alike. In fact in remote rural areas which lack even basic facilities such as potable water, ice packed samples of amniotic fluid are known to be transported long distances, including across state borders! Since determination of foetal sex is not possible until the second trimester, abortions of unwanted female foetuses invariably occur after 12 weeks of pregnancy putting the woman's life at great risk. This trend being on the rise, greater numbers of second trimester abortions are being performed than ever before.

Recently, a Bill was passed in the Lok Sabha seeking to prevent the misuse of pre-natal diagnostic techniques for determining the sex of the unborn child and aborting it in case it turned out to be a female. However passing the legislation is not enough, as its implementation would depend upon a change in the attitude of people.

Legal Aspects of Medical Termination of Pregnancy

THE ISSUES:

The Medical Termination of Pregnancy (MTP) Act of 1971 was the most enlightened piece of legislation of its time. It made abortions legally available to any woman aged 18 years and above, irrespective of her marital status. Its measures were proposed in the spirit of being:

- ☆ a health measure for women
- ☆ a humanitarian measure in case of sex crime
- ☆ a eugenic measure

Its more revolutionary features included —

- ☆ Legalisation of MTP in the event of the failure of contraception (allowed for the first time in the world).
- ☆ Sufficiency of the woman's own request in order for her to gain access to MTP services (concurrence of partner/husband was not required).

The MTP Act at the same time incorporated two major legal conditions for access to abortion services. First, abortion could only be performed by a registered medical practitioner (RMP), meeting stipulated training requirements in gynaecology. Second, abortion could only be performed at a place sanctioned by an appropriate authority as meeting the required standards and facilities prescribed.

The act indemnified against all criminal, legal or any other action, any provider who terminated a pregnancy in observance of the rules and regulations of the Act. Furthermore it absolved the RMP of breaching any or all of the stipulations in a case where an opinion had been formed in "good faith" that intervention was necessary as the continuation of pregnancy would involve a risk to the life of the pregnant woman or grave injury to her physical or mental health. At the same time, the Act was equally explicit in making the termination of pregnancy a punishable offence if conducted by an individual who was not a RMP. The Act envisaged the dissemination of MTP services through the public health system, notably Primary Health Centres (PHC), Community Health Centres (CHC) and District hospitals.

The MTP Act, which in 1971 was ahead of its time, has stagnated and failed to keep up in today's global context of women's rights and legal access to end an unwanted pregnancy. India is among the 13 countries comprising 22% of the world's population where pregnancy may be terminated on broad social and socio-medical grounds. While this may be a better situation than that existing in countries where laws on abortion range from restrictive to a blanket ban (94 countries with 37 % of the world's population), the legal proviso granting abortion on request by the woman still does not exist. India thus lags far behind the 22 countries (comprising 41% of the global population) which have granted women the legal right to terminate a pregnancy (up to varying gestation periods) on request alone.

Another very important fact is that the twin thrusts of the MTP Act of 1971, namely

a: This section is based on the introductory chapters in Chhabra, R. and Nuna, S.C. (1994): Abortion in India- An overview, New Delhi: Veerendra Printers.

liberalization of the grounds for MTP and the medicalization of the process, are often working at cross purposes. While it permits the woman to seek abortion for a wide range of social and socio-medical reasons, it severely restricts the sources of service, which are limited to 'approved' facilities with 'approved' medical practitioners. The availability of such trained and authorised medical personnel and facilities remain limited especially within the public sector. The accessible providers are often either unauthorised or untrained, or both.

Many of the illegal MTP services are actually provided by qualified and 'safe' providers, their illegality stemming only from their failure to go through the cumbersome process of seeking licensure or recording and reporting MTP procedures, as laid down in the MTP regulations. The complicated reporting procedures required, also discourage the providers (authorised ones included) from reporting even those cases where services have been genuinely provided. Illicit monetary gain — public health facility doctors carrying out unauthorised private practice, and the private physicians' desire to evade taxes — also contribute to the overall under-reporting of MTP cases.

Finally, the MTP Act, while permitting the termination of pregnancy on wide ranging grounds, demands that the doctor (authorised RMP) elicit a large amount of antecedent information from the woman in order to determine whether or not termination of the pregnancy falls within the scope delineated by the Act. In effect, neither is the woman the ultimate arbiter of what constitutes danger to her well-being, nor can she escape a detailed explanation to secure the procedure. This lack of confidentiality engendered by the provisions of the Act actually alienate clients from the legal system. Thus, the letter of the MTP Act itself has gone against the very spirit of its creation.

RECOMMENDATIONS:

1. Review the Act and examine areas where the rules and regulations need to be liberalized to strengthen its primary intent of providing safe abortions as a measure for women's health and well-being; and follow this up with action. The possibility of amending the MTP Act to include the provision of abortion on request by women may be considered. Suitable modifications may be introduced to ensure that women's dignity and privacy is not compromised in the process of confirming their eligibility for abortion under the law.

2. Simplify licensing work, decentralize it to the district level and evolve standard guidelines to ensure uniformity. Set a maximum time limit of 3 months for completion of the licensing process, for both personnel and institutions. Particular emphasis should be placed on reducing paper work and administrative demands.

3. Develop mechanisms for stricter enforcement of licensing rules, and vest the authority with district level bodies set up for the purpose.

Improving Access to Safe and Legal Abortions

THE ISSUES:

Physical Infrastructure

The current scenario regarding abortion in India has much more to it than outdated legislation. There is, today, a pronounced gap between the absolute numbers of women requiring MTP services and licensed practitioners and/or facilities available to satisfy this need. The gravity of this undersupply is illustrated by the following figures. There are over 20,000 PHCs and 1563 CHCs in India; 4732 hospitals in the public sector alone; and over 6000 private hospitals and numerous private sector clinics, all of which are eligible under the MTP Act to offer MTP facilities. However, there existed only 7121 'approved' institutions (including hospitals and private facilities) in the entire country as of 1991-92 [1].

To make matters worse, approved MTP service delivery facilities are very inequitably distributed across the states of India. Uttar Pradesh for instance, has 75% more population than Maharashtra but 70% less approved institutions [4]. A primary explanation is that the expansion and maintenance of MTP facilities is the responsibility of the state governments and abortion appears to be low on the list of priorities. Another dimension in the inequitable distribution is the gross disparity in the distribution of approved MTP facilities between the urban and rural sectors. Of the public community health facilities available to the rural population (CHCs and PHCs), a mere 1800 (8%) qualify as 'approved' [1].

Given severe limitations in the number of service delivery facilities, there is little option for many women but to turn to unlicensed and often untrained providers, such as local midwives, female paramedics, and practitioners of indigenous systems of medicine.

Quality of Care

The acute shortage of approved MTP facilities/providers is only part of the story. Equally serious is that many are incapable of providing MTP services owing to the lack of trained personnel and equipment. In a recent study conducted in Gujarat, out of 81 registered public clinics (28 CHCs and 53 PHCs) covered by the study, only 37 (46%) were currently providing MTP facilities. 24 per cent of the remaining had never provided MTPs, and the rest had discontinued. Non-availability of a trained doctor was the reason why services could not be provided in all the CHCs and in 70 per cent of the PHCs not currently providing MTP services [5]. A detailed discussion of training needs follows in the next section.

FOCUS ON GUJARAT

The state of Gujarat, situated on the Western Coast of India is one of the most prosperous and advanced states in the country, due to its industries, oil wells and refineries.

In terms of MTP services, Gujarat can boast of 9.6% of the country's MTP centres to serve its 4.9% share of the country's population. The total number of approved MTP centres in the state is 876. Of these 448 (51.2%) are public sector clinics while the rest i.e 428 (48.8%) are either private or voluntary sector facilities.

Available statistics show that in 1991, the number of MTP cases conducted at the approved clinics was around 16,000. At the same time, recent estimates indicate the number of illegal abortions in the state amount to 0.3 million (Chhabra et. al. 1994). In fact, over the last decade, the number of officially conducted and reported MTP cases have shown a general declining trend (except in 1988). While this may be partly due to the rising share of private sector in MTP services (for which figures are not always available) it is paradoxical, given the steady rise in the number of approved MTP centres during the same period.

Field studies have shown that of the 83 registered government clinics in Gujarat (30 CHCs and 53 PHCs), only 37 currently provide MTP services. The remaining 46 have either never provided MTP facilities or have ceased to do so, mostly because of the lack of trained personnel.

In fact, the scenario on MTP training in the state reveals a wide discrepancy between training needs and the actual facilities. At CHCs, 77% of the doctors conduct MTP while only 70% have received proper training for it. In private clinics, the gap is larger - 94% of the doctors conduct MTP but only 69% are trained. Even among trained doctors, 9% and 17% of the doctors in the urban and rural clinics respectively have performed no MTP procedures during their training (notwithstanding the mandatory requirement of 25 cases to be undertaken during the course). As a result in some clinics, "trained" doctors do not offer MTP services because they lack confidence to do so.

In sum, Gujarat is pretty much representative of the overall MTP scenario in India. Despite being a relatively prosperous state, like the rest of the country, it too requires activation of political will and the state machinery along with the mobilization of positive public opinion to make its MTP programme a success.

Source

(a) Perspective on Abortion : Gujarat, Dr. S.K. Verma, Commissioner (Family Welfare), MOHFW, Govt. of Gujarat.

(b) Situational Analysis of Abortion Services on Gujarat, Ms. Sandhya Barge, Mr. Manjunath Kini and Ms. Sunita B. Nair, Centre for Operation Research and Training (CORT), Baroda.

Equipment also is in chronically short supply. Expert technical review in recent years has led to a change in the technical standards of MTP equipment manufacture, but good quality equipment which are low cost and easy to maintain are not easily available.

Where MTP services are indeed available, the procedure adopted almost universally is the Dilation and Curettage (D&C), even though safer and simpler procedures exist and are widely used in other countries. Since 1980, the Government of India has emphasised a changeover to safer and simpler suction curettage procedures for MTP, from the earlier sharp curettage procedures. But equipment replacement/expansion in the public sector has been hampered by financial constraints.

Further, Menstrual Regulation (MR), a variant of vacuum aspiration for early gestation abortion is not recognised, let alone propagated in the public sector. This occurs despite the fact that MR is a simple, safe, and effective method with a much lower complication rate than D&C, one which can easily be performed in field situations with basic training. MR equipment is not provided at government facilities, nor are doctors trained in their use.

MTP services in most approved facilities do not include pre and post-procedural counselling services. Counselling is an important component of MTP and contraceptive service provision which enables women to make an informed choice. Yet, it has remained a neglected area, with little resources or training devoted to it.

All these factors contribute to client dissatisfaction with the quality of services provided. Several studies have shown that a major reason why women opt to use non-approved centres/services for abortion is that they are not satisfied with the services available in PHCs [6]. Of the reasons frequently given, most were to do with provider attitudes:

- ☆ the lack of proper care at health centres
- ☆ an absence of follow-up care
- ☆ the lack of privacy and disregard for confidentiality
- ☆ the high fee charged by PHC doctors
- ☆ insistence that abortion seekers should undergo sterilisation/get an IUD inserted (as a precondition for services)
- ☆ non-availability of drugs at PHC [6]

In the Gujarat study cited above, only 62 per cent of the PHCs offered auditory privacy, and 55 per cent visual privacy to MTP clients. Further, 80 per cent of the PHCs did not have a clean toilet, and 41 per cent did not have an operating table with a clean rubber sheet [5]. Small investments could set right these anomalies, given the commitment to do so.

The attitude of medical practitioners providing abortions is such that they do not see the seekers as clients who choose to avail of a service in order to secure their well-being. Instead, they tend to view the women as "patients" who are "ill", and MTP as a necessary evil required to "treat" their condition. At the same time the providers often tend to adopt a position of moral superiority towards

their clients, treating them as " wrong - doers" who have committed the "crime" of irresponsible sexual behaviour. On the other hand, indigenous providers may lack training, but enjoy the confidence of and proximity to the local populace.

The situation in India where MTP is legal but where more often than not, legal and/or safe services are inaccessible, is perhaps unparalleled elsewhere in the world. A consensus emerged from the meeting that it cannot be allowed to continue, and that the need to improve women's access to high quality MTP services is urgent.

RECOMMENDATIONS:

1. The public health system needs to be strengthened to ensure that:

   (a) Immediate : All CHCs have facilities to perform first and second trimester abortions, including equipment, infrastructural requirements and trained personnel.

   There is coordination between licensed facilities (PHCs and CHCs), trained providers and equipment supply, so that licensed facilities become capable of providing abortion services.

   (b) Short-term : All PHCs be equipped to perform abortions up to 10 weeks.

2. Priority action is needed to improve the equipment supply to CHCs and PHCs. There is a need to expand indigenous manufacture of quality equipment.

3. Steps should be taken to implement the Government of India's policy for a change-over to suction curettage, starting with the investigation of existing bottle necks and appropriate remedial steps. The possibility of using MR procedures for early gestation MTPs should be explored.

4. The supply of drugs to CHCs and PHCs is at best erratic, and at worst, non-existent. The key drugs which must be available at any health centre performing MTPs should be identified and a system for ensuring supply of these drugs on a regular basis needs to be put in place.

5. Quality of care in approved MTP centres needs to be considerably improved.

   a) Provider attitudes :

   ☆ Counselling should be an integral part of services offered.

   ☆ Privacy and dignity of MTP clients should be upheld.

   ☆ Acceptance of a contraceptive method should in no case be a prerequisite for availing abortion services.

   b) Screening:

   ☆ There must be proper screening to ensure that women can safely undergo the procedure. If found unfit, the provider should ensure medical fitness through necessary treatment, or refer to a higher level facility.

c) Safety Standards :

☆ Rules and standards laid down in the 1971 MTP Act, which do not differentiate between facilities performing first versus second trimester abortions need to be reviewed. Separate safety standards are required for first and second trimester abortions.

☆ There is need for enquiry into abortion-related complications/deaths to assess what went wrong and where corrective action is needed. This process of Medical Audit needs to be a part of the system to ensure safer and better quality services.

Training of Service Providers

THE ISSUES:

The next set of problems with the Government's MTP delivery system is associated with the training of its personnel. The training curriculum in force at the authorised training centres is designed by the Government of India and comprises both theory and practical sections.

It aims to cover two categories of physicians:

(i) physicians with a post graduate diploma or degree in Obstetrics & Gynaecology (OB/GYN) or doctors with at least 3 years OB/GYN experience likely to work in hospitals with major surgical facilities and

(ii) physicians with little or no experience in OB/GYN.

A minimum of 25 MTP procedures conducted independently under supervision is mandatory for either category. Despite its comprehensive nature, implementation of this training curriculum is attenuated by many factors.

The first is the shortage of accredited training institutions. India has a meagre total of 162 authorised MTP training centres (1989-90) across the country. This inadequacy persists despite the existence as of 1989-90 of over a thousand centres at district and sub-district levels capable of offering training in MTP which only lack authorization for this purpose. The government has not fully recognized the potential of non-governmental organizations providing MTP services as trainers in this area.

Getting doctors away from their busy schedules for the purpose of training also becomes especially difficult, given the meagre travelling and daily allowances paid to them. Often doctors have to invest their own funds in order to undergo training, so enthusiasm to attend training is understandably low, especially if the training centre is located far away.

Institutional support for training programmes is so low (Rs.100/- per trainee per course, to a maximum of 20 trainees per course per institution) that it does not allow an institution to offer an imaginative package of training materials to sustain the trainees' interest or produce training manuals which would enable the trainee to refresh his or her memory of the compressed technical course.

A problem with the practical part of the training is the sheer unavailability of the mandatory 25 MTP cases for each trainee. Most government facilities have limited abortion case loads and there too, the house residents are given preference over outside trainees when it comes to obtaining hands-on experience. In fact, on being interviewed by a team of researchers in Gujarat, a doctor's comment on the number of procedures a trainee actually gets to perform was: "..If you ask me honestly, the number of MTP cases they perform is very few but as you are taking an official interview and writing my answer, I will say they conduct 25 cases." The researchers subsequently found the actual number to be around 3-4 cases per physician. It is also uncertain as to what percentage of first and second trimester cases each trainee deals with in the course of his or her training [5].

The training programme does not apply to non-medical/paramedical personnel such as midwives. This may be construed as a deficiency given the success of menstrual regulation programmes such as that of neighbouring Bangladesh, which utilizes non-physician or paramedical personnel to expand access to abortion care. They provide family planning and menstrual regulation services to women in rural areas while maintaining what appears to be adequate standard of care [7].

Some other practical problems with the Indian training set-up are:-

1. The facilities available at the Indian medical colleges are much more than what is available at the health centres. This means that the trainee is exposed to more sophisticated medical support than she or he will actually function in.

2. The training programme does not include care and maintenance of the equipment or emergency procedures in the event of field realities such as power failures.

3. Doctors undergoing the training course are not trained in the psychological aspects of handling MTP procedures - including their own attitude and behaviour towards the client, on motivating the client, on providing pre- and post-procedural counselling to the client.

4. Training courses provide no input on alternative methods of MTP (Menstrual Regulation, RU 486 etc.)

5. The lack of focus on training for paramedical staff on diagnosis, emergency detection and management, and follow-up of cases is an important gap, given the fact that in rural settings, doctors are seldom at hand to attend to the cases.

RECOMMENDATIONS :

1. Standard training protocols and manuals need to be developed for all categories of MTP trainees.

2. Training should be provided on a priority basis to medical officers of CHCs, followed by those in PHCs.

3. There is a gap between current MTP training capabilities and the total number of trained doctors who are required. Existing training centres and institutes need to be strengthened, and other centres of training need to be added, including non-governmental organizations who have been identified as providing quality services.

4. Training standards have to be maintained to ensure that the minimum of 25 independent procedures is performed by every single trainee. To ensure an adequate case load so that this will be possible, practical hands-on training could be provided at the CHC or PHC, or at a non-governmental organization's clinic, while theoretical training could be provided at a hospital or a medical college.

5. Revision of the current training curriculum should include:

   - ☆ Social and psychological aspects of handling MTP procedures, including provider's attitude and behaviour

towards the client, client-motivation and counselling.

- ☆ Technological developments, including evolving medical standards and new therapeutic procedures (for eg: RU 486, high level infection prevention).

6. Systematic refresher training at two or three year intervals should be planned and implemented.

7. Physician training apart, training to non-physicians on counselling, post-abortion family planning, motivation and other related issues should be undertaken.

8. The feasibility of training Auxiliary Nurse Midwives (ANMs) to perform early gestation menstrual regulation procedure should be seriously examined through implementation of pilot projects.

Public Education and Communication

THE ISSUES:

Close to twenty-five years after the passing of the MTP Act, a majority of the women are not aware of the availability of free and legal MTP services provided by the government programme.

According to an ICMR study carried out in 1989, while 86 per cent of the women knew about induced abortion, only 47 per cent knew that MTP services were available at the PHC, and 37 per cent aware that abortion services were legal [6]. Public education and communication efforts with respect to MTP have been virtually ignored, even while vigorous efforts have been done in relation to family planning. It is therefore, not a lack of technology or expertise, but only of political will.

Media treatment and coverage given to the MTP issue is influenced by political and social pressures. While political backing ensures the coverage of the subject, "social purdah" surrounding abortion causes the publicity and educational messages to be truncated, conveying partial, inadequate and sometimes misleading information. Balanced coverage of the related issues of sex education, contraception and reproductive health are rare. Sometimes, a well constructed message is rendered ineffective due to mishandling of the media strategy for its dissemination.

There is an attitudinal bias in the media whereby MTP is not treated on par with other health issues of women such as safe motherhood, breast-feeding and contraception. Instead, abortion is perceived merely as a necessary evil which must only be tolerated, rather than be given any special attention. Consequently, funding for MTP coverage in the media is scarce, awareness regarding MTP legislation and availability of free services is low, and the dangers of seeking abortion services from untrained providers are not adequately conveyed.

RECOMMENDATIONS:

1. IEC suited to local community needs using multi-media approaches, should focus on:
   a. The lower risk of abortion done within 10 weeks of gestation.
   b. Locations where MTP services can be accessed freely without pre-conditions.
   c. The importance of seeking services from trained service providers and the corresponding hazards of illegal abortion by untrained persons.
   d. Encouraging sexual responsibility amongst both men and women, and promoting male involvement in contraception and family planning.
2. Family life education, including sex education and sexuality, needs to be made an integral part of school/college curriculums, as teenage girls are at maximum risk of adverse outcomes both during pregnancy and childbirth and during abortions.
3. The focus of media needs to be on treating abortion as part of a woman's right to safeguard her reproductive health. There is a need to handle this carefully, as too much emphasis on abortion may result in enhancing the status of abortion as an alternative to contraception.

Research Needs

THE ISSUES:

An important barrier to the rationalisation of MTP legislation and services is the lack of proper research into the issue. Government figures are sadly inadequate, while studies inevitably show that the scale of the problem is far larger than acknowledged. Without adequate research into the actual scenario, proper and effective corrective measures (planning and execution) are impossible.

Further, the ground realities of the indigenous providers are being ignored and there is practically no research into evolving a flexible service delivery system which can integrate the vast numbers of private and indigenous providers and use them to advantage.

Research into emerging new techniques of MTP like RU 486 also need to be widespread and well developed, to take into account the special circumstances of Indian women (especially rural women) who will actually use the techniques - their life style, income, health and nutritional status etc. - before releasing them into an uncontrolled and unregulated market.

RECOMMENDATIONS:

In order to truly understand the issue of abortion and abortion needs there is a need to undertake an in-depth research in the following areas:

1. Studies of women who seek abortion, to obtain greater insight into women's decision-making, and their needs related to accessing abortion services.

2. Situational analysis of abortion services such as those undertaken by the Centre for Operations Research and Training (CORT) in Gujarat and Maharashtra.

3. Research and pilot designing of alternative service delivery approaches e.g.

   (a) Using ANMs/paramedics for providing menstrual regulation.

   (b) Suitability, safety, efficacy and acceptability of new technologies such as RU 486.

Funding

THE ISSUES:

Funding is a major problem plaguing the public sector MTP service delivery system in India. The Financial Memorandum attached to the MTP bill presented to the Rajya Sabha in 1969 sought support for the creation of facilities at government hospitals to meet the demands that would arise from the enactment of the bill. At that time, it sought to provide for a recurring expenditure of Rs.2.4 million and a non-recurring expenditure of Rs.1.93 million, figures which were well short of actual requirements even at that time. In the event, the Financial Memorandum simply disappeared, and the provision of support for MTP services devolved onto the state health sector - a sector well known to be chronically starved of resources.

In 1986-87, the Ministry of Health and Family Welfare (MOHFW) formulated a central scheme for the expansion of MTP facilities by providing Government of India funds on a year-to-year basis. The funding pattern outlined in this scheme has been Rs. 1/- given for the support of a MTP cell for each MTP performed; a total expenditure of Rs.100 per trainee doctor to a maximum of 20 trainees per training centre a year. In 1993, Rs.15 was given toward drugs and dressing per MTP case. However, even these provisions are not being followed everywhere. The Government made no provision for the purchase of MTP equipment. It is no surprise perhaps that with such meagre funding, no real progress in expanding the coverage or quality of MTP services have been made.

In the case of funding from external agencies, a WHO grant of $300,000 for equipment supply (including imports) is awaiting concrete specifications on utilization from the MOHFW. But there is a continuing ambivalence on the part of international and bilateral donor agencies to fund MTP services/ equipment supply largely because of continuing political sensitivities abroad.

RECOMMENDATIONS:

1. An essential requirement for any meaningful improvement in the service delivery system for abortion is the backing of adequate funding. Therefore, integrating MTP services as part of safe motherhood programme which has substantial funds available should help in accessing better funding for MTP services.
2. Given that access to safe abortion was on the agenda at the International Conference on Population and Development (ICPD), it is an appropriate time to seek funding for abortions as a part of women's development and health from donor agencies, who to date have not played an active role in supporting this programme component.

Role of Non Governmental Organisations

THE ISSUES:

The role of Non-Governmental Organisations (NGOs) needs to be carefully examined as increased NGO involvement is essential to expand MTP services. In India, 3 NGOs may be considered as frontrunners in the provision of reproductive health care services.

Parivar Seva Sanstha (PSS) is a pioneer in providing safe, reliable and confidential MTP services, through its countrywide network of Marie Stopes Clinics.

The Health Promotion Society has a solitary clinic (Pearl Centre) in Bombay which functions as a self-generating no-profit-no-loss institution. Despite high workload, they have been providing quality abortion services.

Another NGO having the largest voluntary sector network of clinical family planning services,Family Planning Association of India (FPAI) is interested in providing MTP services.

Together, these and other NGOs have considerable experience, and expertise at their disposal, which need to be better tapped and given encouragement and support,so as to improve MTP services in India.

RECOMMENDATIONS:

1. NGOs can and must be encouraged to play a much more active role in all aspects of abortion services, including provision of quality MTP services, training, information, education and communication; counselling; and research.

2. Given their flexibility, NGOs are in a particularly advantageous position to experiment with new and innovative approaches to MTP service-delivery, training, and IEC and to carry out intervention research in these areas. Grassroots NGOs could also play a role in informing policy makers of women's perspectives and expectations of what constitutes an acceptable and satisfactory MTP service delivery package.

Formation of Advisory Committee

An overarching recommendation of the workshop was related to the formation of central and state level committees in order to work out the details and logistics of implementation of the recommendations made under various topics above.

ISSUES OF IMMEDIATE CONCERN:

(a) Review of the MTP Act rules and regulations with specific emphasis on reducing paper work and administrative demands.

(b) Simplification of licensing procedures so that action could be taken at the district level for both the issuing of licenses and the enforcement of licensing rules.

(c) Funding for MTPs both in terms of provision of services as well as infrastructure development. Funding requirements and sources of fund to ensure quality service to be looked into.

(d) Supply of equipment, surgical supplies and drugs essential for MTP services to be streamlined, and strategies for dealing with bottlenecks suggested.

(e) Systematizing training and retraining of doctors to ensure an adequate number of skilled personnel to man existing approved government facilities; improving the quality of training; development of training manuals and protocols for all categories of service providers.

(f) Expanding IEC efforts to encourage women to access trained and licensed providers for abortion.

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Agenda

FEBRUARY 22, 1994

09:30 - 10:00 am	Registration
10:00 - 10:10 am	Welcome - Dr. Alka Dhal, Consultant Parivar Seva Sanstha
10:10 - 10:30 am	Inaugural Ceremony with Opening Remarks - Dr. Leela Phatak Ex-Commissioner Health and Family Welfare
10:30 - 10:40 am	Objectives of the Conference - Sudha Tewari, Managing Director Parivar Seva Sanstha
10:40 - 11:00 am	Place of Abortion in Womens' Health - Dr. Banoo Coyaji, Chairperson KEM Hospital Society.
11:00 - 11:45 am	Overview on Status of Abortion - Ms. Rami Chhabra
11:45 - 12:00 noon	Tea Break
12:00noon - 01:30pm	Session I Chairperson : Dr. Leela Phatak, Ex-Commissioner Health and Family Welfare Perspectives on Abortion with special reference to respectiveState. Presentations by - Smt. Reena Mukherjee, Asst. Director (FW) Ministry of Health & Family Welfare Uttar Pradesh

Dr. Rajaram, Deputy Director General,
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01:30 - 02:30 pm	Lunch
02:30 - 3:30 pm	Session II

- Working papers/Issues in abortion -

Chairperson for the Session :
Dr. Datta Pai, Pearl Centre, Bombay

- Dr. Daxa Patel	:	Experiences of working with Rural and tribal community
- Ms. Sandhya Barge	:	Situation Analysis of Abortion services in Gujarat
- Prof.Rohit Bhatt	:	Training Needs for Abortion

03:30 - 03:45 pm	Tea

03:45 Onwards	Working groups	
	Group I	: Policy Issues, Resource Allocation and Legal Aspects in Abortion.
	Group II	: Improving Quality of Abortion Services - Medical Aspects.
	Group III	: Improving Quality of Abortion Services - Non-Medical Aspects
	Group IV	: Training and Licensing Issues
	Group V	: Technology-New Approaches
	Group VI	: Research Needs for Abortion

FEBRUARY 23, 1994

09:00 - 11:00 am	Working Groups continue
11:00 - 01:00 pm	Presentation of Working Groups' Recommendations
	Chairperson:
	Dr. Badri Saxena, Sr. Dy. Director General, Indian Council of Medical Research, Delhi
01:00 - 02:30 pm	Lunch
02:30 - 4:00 pm	Action Plan for the future
	Chairperson:
	Dr. Banoo Coyaji, Chairperson KEM Hospital Society, Poona.